



Health Insurance Exchange Workgroup

August 2, 2012

Presented by:

Bill Deal, Director of Insurance

Dick Armstrong, Director of Health and Welfare

Tom Donovan, Deputy Director, Insurance

Penelope Schiebert, Project Staff



Agenda

1. Overview of Idaho Market
2. Review of Prior DOI Activities/Planning for Exchange
3. Overview of PPACA Insurance and Market Reforms
4. Exchange Overview
5. Exchange Options and Critical Dates
6. Charge to Working Group & Next Steps



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Health Survey Report

**Idaho Individuals Covered-End of Survey Year
Fully – insured plans only
3 Year Comparison**

Individual Health Benefit Plans

Carrier Reported Data			
Type	2009	2010	2011
Association	703	2,438	1,551
Direct / Producer Marketed	85,527	87,644	83,119
Trust	6	3	148
HRP-Individual Basic	41	26	43
HRP-Individual Standard	218	144	117
HRP-Individual Catastrophic A	226	191	155
HRP-Individual Catastrophic B	617	581	599
HRP-HSA Compatible Health Benefit Plan	4,490	9,969	2,591
Franchise Disability	208	154	0
Total	92,036	101,150	88,323

Individual Health Benefit Plans

Year to year % of Change	2009 - 2010	2010 - 2011
Association	246.8%	-36.4%
Direct / Producer Marketed	2.5%	-5.2%
Trust	-50.0%	4833.3%
HRP-Individual Basic	-36.6%	65.4%
HRP-Individual Standard	-33.9%	-18.8%
HRP-Individual Catastrophic A	-15.5%	-18.8%
HRP-Individual Catastrophic B	-5.8%	3.1%
HRP-HSA Compatible Health Benefit Plan	122.0%	-74.0%
Franchise Disability	-26.0%	-100.0%
Total	9.9%	-12.7%

Individual Health Benefit Plans

3 Year Trend	2009 - 2011
Association	120.6%
Direct / Producer Marketed	-2.8%
Trust	2366.7%
HRP-Individual Basic	4.9%
HRP-Individual Standard	-46.3%
HRP-Individual Catastrophic A	-31.4%
HRP-Individual Catastrophic B	-2.9%
HRP-HSA Compatible Health Benefit Plan	-42.3%
Franchise Disability	-100.0%
Total	-4.0%

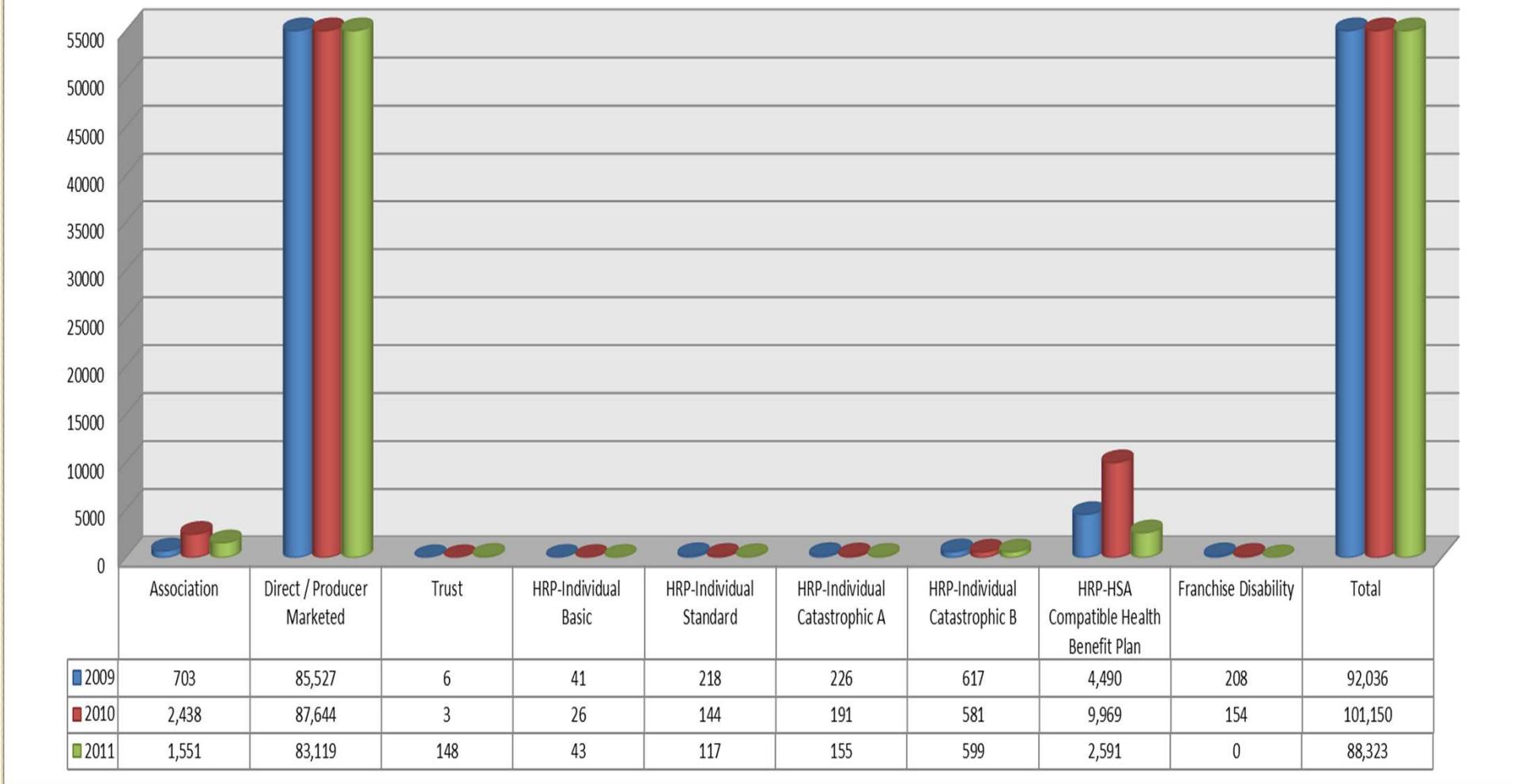
Individual Health Benefit Plans

Actual Administrator reported Data (Ameriben)			
Type	2009	2010	2011
HRP-Individual Basic	27	26	27
HRP-Individual Standard	175	151	126
HRP-Individual Catastrophic A	218	200	179
HRP-Individual Catastrophic B	648	606	606
HRP-HSA Compatible Health Benefit Plan	327	538	718



Individual Health Benefit Plans

Individual Health Benefit Plans



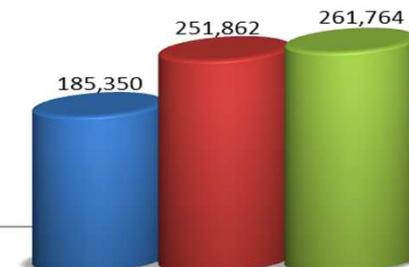
Individual –Dental Benefit & Vision

Type	2009	2010	2011
Dental Benefit	185,350	251,862	261,764
Vision	3,971	4,797	4,035

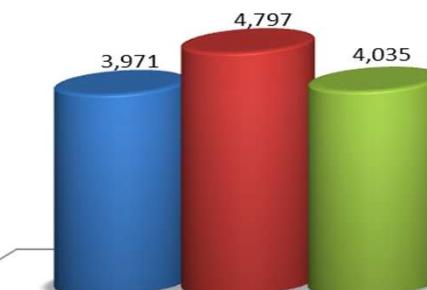
Year to year % of Change	2009 - 2010	2010 - 2011
Dental Benefit	35.9%	3.9%
Vision	20.8%	-15.9%

3 Year Trend	2009 - 2011
Dental Benefit	41.2%
Vision	1.6%

Dental Benefit



Vision



Group – Small & Large Employer Health Benefit Plans - (Major Medical)

Type	2009	2010	2011
Small Employer (2-50)	105,240	95,360	88,090
Other Employer (51+)	212,780	203,558	200,587
Multiple Employer Association or trust	30	986	1,280
Other: Other Association or Trust	3,342	1,125	4,090
Federal Government Benefit Plans	46,734	48,222	50,956
Total	368,126	349,251	345,003

Group – Small & Large Employer Health Benefit Plans-

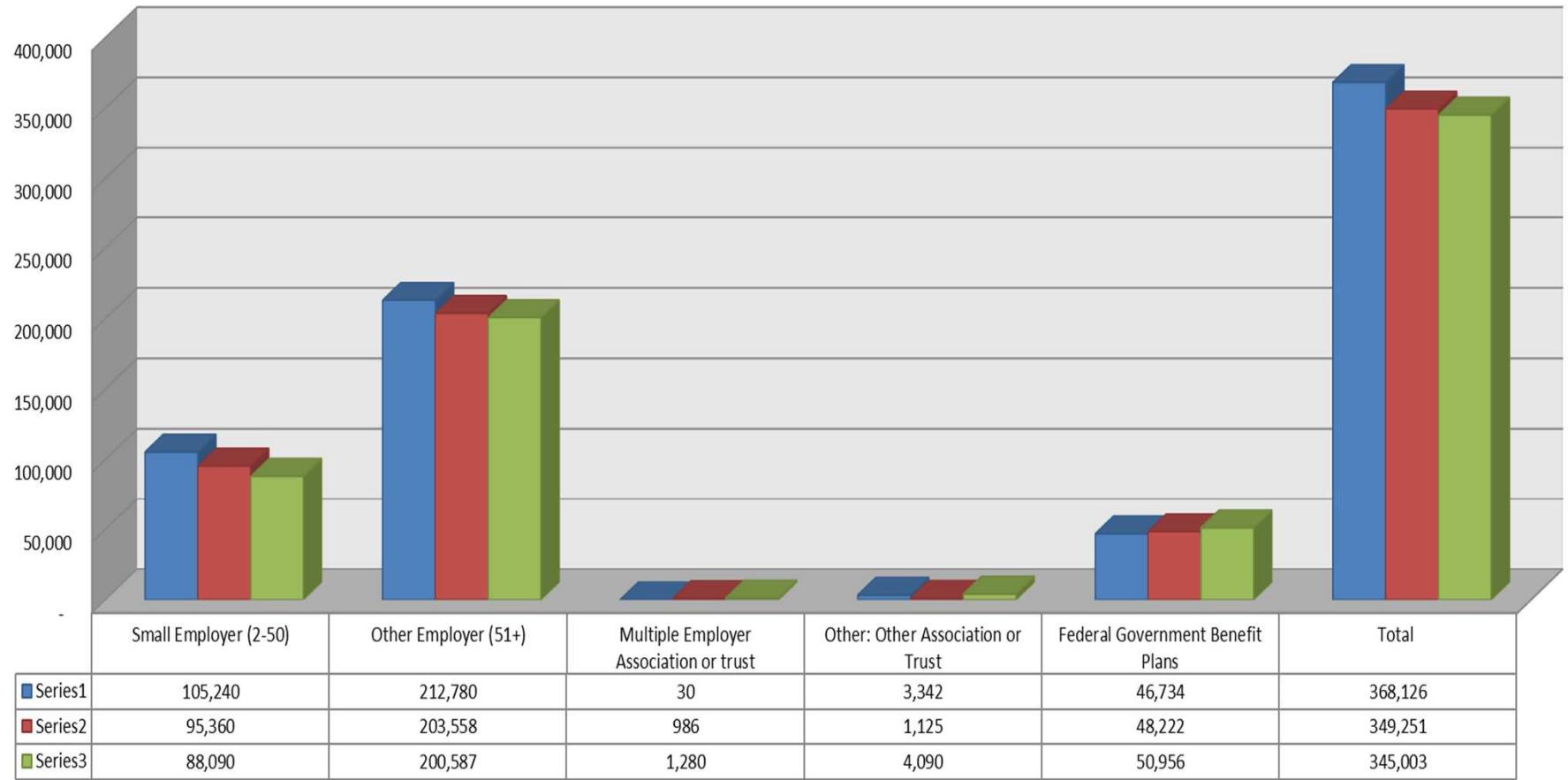
Year to year % of Change	2009 - 2010	2010 - 2011
Small Employer (2-50)	-9.4%	-7.6%
Other Employer (51+)	-4.3%	-1.5%
Multiple Employer Association or trust	3186.7%	29.8%
Other: Other Association or Trust	-66.3%	263.6%
Federal Government Benefit Plans	3.2%	5.7%
Total	-5.1%	-1.2%

Group – Small & Large Employer Health Benefit Plans

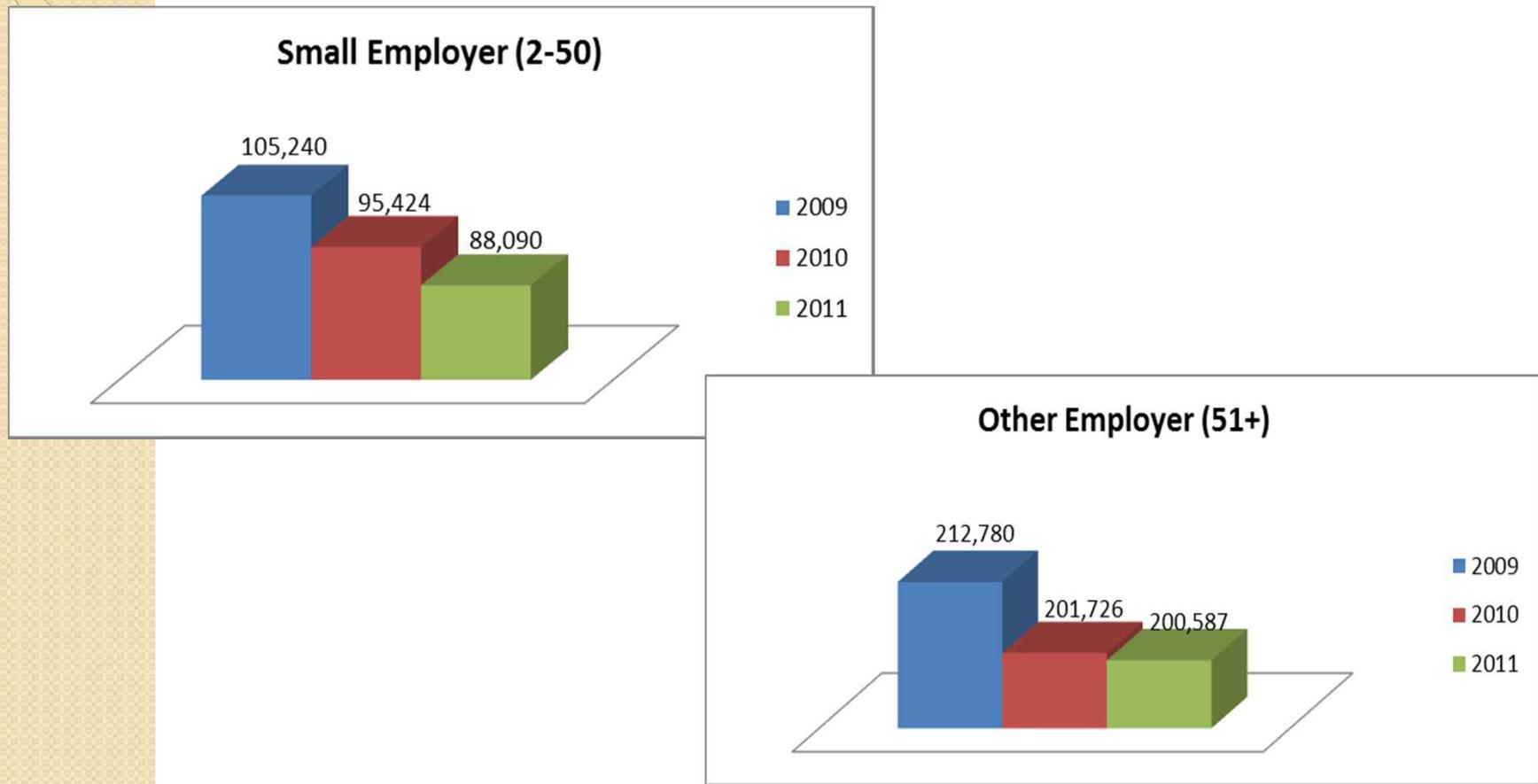
3 Year Trend	2009 - 2011
Small Employer (2-50)	-16.3%
Other Employer (51+)	-5.7%
Multiple Employer Association or trust	4166.7%
Other: Other Association or Trust	22.4%
Federal Government Benefit Plans	9.0%
Total	-6.3%

Group – Small & Large Employer Health Benefit Plans

Small & Large Employer Health Benefit Plans



Group – Small & Large Employer Health Benefit Plans

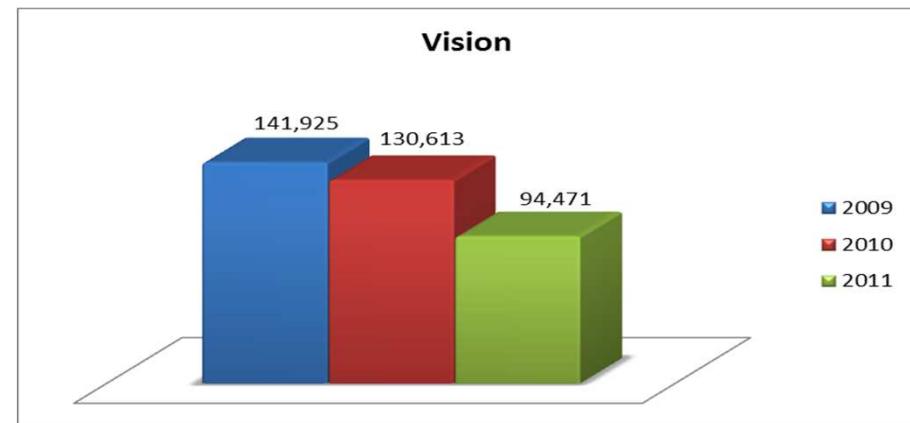
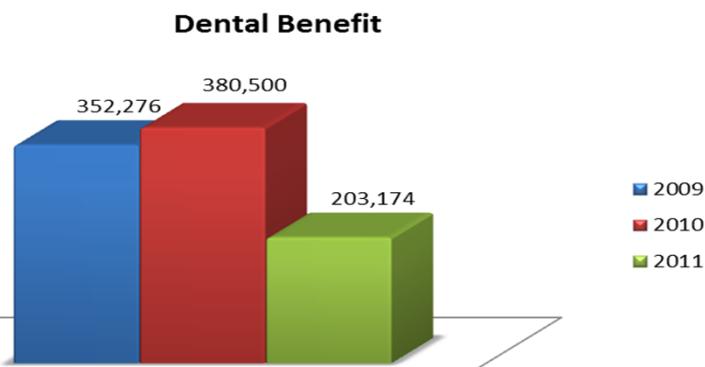


Group – Dental Benefit and Vision

Type	2009	2010	2011
Dental Benefit	352,276	380,500	203,174
Vision	141,925	130,613	94,471

Year to year % of Change	2009 - 2010	2010 - 2011
Dental Benefit	8%	-47%
Vision	-8%	-28%

3 Year Trend	2009 - 2011
Dental Benefit	-42.3%
Vision	-33.4%



Health Insurance Coverage of the Total Population (2009-2010)

	Idaho #	Idaho %
Employer	733,300	48%
Individual	126,500	8%
Medicaid	203,600	13%
Medicare	182,800	12%
Other Public	18,300	1%
Uninsured	262,400	17%
Total	1,526,900	100%

<http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=14&cmprgn=1> retrieved August 1, 2012



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- Exec. Order 2010-15 – Establishing the Governor's Idaho Health Care Council
- Health Insurance Accessibility and Affordability Workgroup



Key Issues Discussed During Process

1. Goal – purpose of an Idaho exchange
2. Idea of a single exchange to provide coverage for individuals and small employers
3. Set up an entity that was an independent public body corporate and politic
4. Governed by a board appointed by the governor, nature of terms, confirmation by Senate, removable for cause or at will
5. Makeup of the board re: class of those persons eligible, including extent of consumer, business, and insurance industry representatives
6. Definitions – whether to track federal regulations
7. Desire for and extent of openness and transparency, e.g. open meeting law application, public records law
8. Extent staff would be authorized; authority to contract/procure; whether state purchasing rules would apply
9. Details to be set forth in a plan of operation document; sources of funding
10. Role of agents and brokers (insurance producers) and navigators in an Idaho Exchange, and idea of licensure or registration required of navigators
11. Whether emergency needed; sunset clause – or exit language



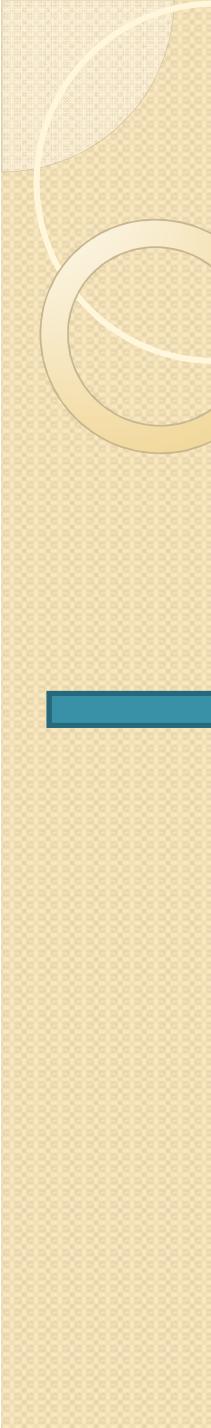
Process

- Open drafting process – much input
- Draft sent to HHS for their review
- Draft was not introduced or addressed by a legislative committee
 - HB 433 was introduced by Rep. Chew but did not progress;
 - House Concurrent Resolution 45 encouraging health insurers to develop a private exchange was adopted by the House but did not advance in the Senate.



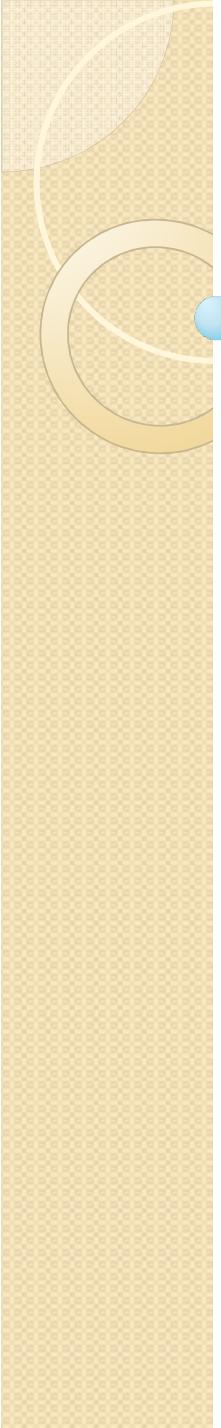
Progress to Date

- Stakeholder Meetings
- Implications Analyses of
 - Plan Management in Partnership
 - Consumer Assistance in Partnership
 - Eligibility and Enrollment (Assess vs. Determine)
- Participated in Survey Studies
 - Business Manager Outlook
 - Shopping Pathways
 - Small Business Market
 - Market Segments
- Reviewed Other States' Approaches



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Overview of PPACA Insurance and Market Reforms



SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS

(a) Prohibiting Discriminatory Premium Rates-

(1) IN GENERAL- With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market--

(A) such rate shall vary with respect to the particular plan or coverage involved only by--

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1.



SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE

(a) Guaranteed Issuance of Coverage in the Individual and Group Market- Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.



SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE

(a) In General- Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.



SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS

(a) In General- A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.



SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS

(a) In General- A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (1) Health status.
- (2) Medical condition (including both physical and mental illnesses).
- (3) Claims experience.
- (4) Receipt of health care.
- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability (including conditions arising out of acts of domestic violence).
- (8) Disability.
- (9) Any other health status-related factor determined appropriate by the Secretary.



SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE

- (a) Coverage for Essential Health Benefits Package- A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.
- (b) Cost-sharing Under Group Health Plans- A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).
- (c) Child-only Plans- If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.
- (d) Dental Only- This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).



SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS

- (a) Essential Health Benefits Package- In this title, the term 'essential health benefits package' means, with respect to any health plan, coverage that--
 - (1) provides for the essential health benefits defined by the Secretary under subsection (b);
 - (2) limits cost-sharing for such coverage in accordance with subsection (c); and
 - (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

- (b) Essential Health Benefits-
 - (1) IN GENERAL- Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:
 - (A) Ambulatory patient services.
 - (B) Emergency services.
 - (C) Hospitalization.
 - (D) Maternity and newborn care.
 - (E) Mental health and substance use disorder services, including behavioral health treatment.
 - (F) Prescription drugs.
 - (G) Rehabilitative and habilitative services and devices.
 - (H) Laboratory services.
 - (I) Preventive and wellness services and chronic disease management.
 - (J) Pediatric services, including oral and vision care.

(c) Requirements Relating to Cost-Sharing-

(1) ANNUAL LIMITATION ON COST-SHARING-

- (A) 2014- The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
- (B) 2015 AND LATER- In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--
 - (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
 - (ii) in the case of other coverage, twice the amount in effect under clause (i).
- If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.



(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS-

(A) IN GENERAL- In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed--

- (i) \$2,000 in the case of a plan covering a single individual; and
- (ii) \$4,000 in the case of any other plan.
- The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(3) COST-SHARING- In this title—

(A) IN GENERAL- The term 'cost-sharing' includes—(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan

- (d) Levels of Coverage-
 - (1) LEVELS OF COVERAGE DEFINED- The levels of coverage described in this subsection are as follows:
 - (A) BRONZE LEVEL- A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.
 - (B) SILVER LEVEL- A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
 - (C) GOLD LEVEL- A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
 - (D) PLATINUM LEVEL- A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.



Overview of PPACA Requirements Related to an Exchange

SEC. 1301. QUALIFIED HEALTH PLAN

(a) Qualified Health Plan- In this title:

(1) IN GENERAL- The term 'qualified health plan' means a health plan that--

- (A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;
- (B) provides the essential health benefits package described in section 1302(a); and
- (C) is offered by a health insurance issuer that—
 - (i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;
 - (ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;
 - (iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and
 - (iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS

(b) American Health Benefit Exchanges-

(1) IN GENERAL- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State that--

- (A) facilitates the purchase of qualified health plans;
- (B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a 'SHOP Exchange') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and
- (C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES- A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary-

(1) Secretary shall, by regulation, establish criteria for the certification of health plans as QHPs - at a minimum--

- (A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;
- (B) ensure a sufficient choice of providers (consistent with network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;
- (C) include within networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals;
- (D)(i) be accredited with respect to local performance on clinical quality measures . . . as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans; or
- (ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;
- (E) implement a quality improvement strategy described in subsection (g)(1);
- (F) utilize a uniform enrollment form that qualified individuals and qualified employers may use...;
- (G) utilize the standard format established for presenting health benefits plan options; and
- (H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) RULE OF CONSTRUCTION- Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) RATING SYSTEM- The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(d) Requirements-

(1) IN GENERAL- An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) OFFERING OF COVERAGE- (A) IN GENERAL- An Exchange shall make available qualified health plans to qualified individuals and qualified employers.(B) LIMITATION-

(i) IN GENERAL- An Exchange may not make available any health plan that is not a qualified health plan.

(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS- Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS-

(A) IN GENERAL- Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS-

(i) IN GENERAL- Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

- (ii) STATE MUST ASSUME COST- A State shall make payments--
 - (I) to an individual enrolled in a qualified health plan offered in such State; or
 - (II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled; to defray the cost of any additional benefits described in clause (i).

(d) (4) FUNCTIONS- An Exchange shall, at a minimum--

- (A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;
- (B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- (C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- (D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);
- (E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;
- (F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(d)(4) (G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because--

- (i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
- (ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(d)(4)(I) transfer to the Secretary of the Treasury--

- (i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;
- (ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because--
 - (I) the employer did not provide minimum essential coverage; or
 - (II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
- (iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);
- (J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and
- (K) establish the Navigator program described in subsection (i).

(5) FUNDING LIMITATIONS-

(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS- In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) PROHIBITING WASTEFUL USE OF FUNDS- In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) CONSULTATION- An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including--

- (A) educated health care consumers who are enrollees in qualified health plans;
- (B) individuals and entities with experience in facilitating enrollment in qualified health plans;
- (C) representatives of small businesses and self-employed individuals;
- (D) State Medicaid offices; and
- (E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS- An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification-

(1) IN GENERAL- An Exchange may certify a health plan as a qualified health plan if--

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan--

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) PREMIUM CONSIDERATIONS- The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase.



(3) TRANSPARENCY IN COVERAGE-

(A) IN GENERAL- The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

- (i) Claims payment policies and practices.
- (ii) Periodic financial disclosures.
- (iii) Data on enrollment.
- (iv) Data on disenrollment.
- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.
- (ix) Other information as determined appropriate by the Secretary.

1311 (f) Flexibility- (1) REGIONAL OR OTHER INTERSTATE EXCHANGES- An Exchange may operate in more than one State if-- (A) each State in which such Exchange operates permits such operation; and (B) the Secretary approves such regional or interstate Exchange. * * *

(3) AUTHORITY TO CONTRACT- (A) IN GENERAL- A State may elect to authorize an Exchange established by the State under this section to [contract] with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY- In this paragraph, the term 'eligible entity' means-

(i) a person--(I) incorporated under, and subject to the laws of, 1 or more States; (II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

1311(g) Rewarding Quality Through Market-Based Incentives-

(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--

(A) improving health outcomes . . . ; B) the implementation of activities to prevent hospital readmissions ; C) the implementation of activities to improve patient safety and reduce medical errors ; (D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities,

(2) GUIDELINES- The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS- The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted ...

(h) Quality Improvement-

(1) ENHANCING PATIENT SAFETY- Beginning on January 1, 2015, a qualified health plan may contract with-(A) a hospital with greater than 50 beds only if such hospital-(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and (ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or (B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) EXCEPTIONS- The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) ADJUSTMENT- The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) Navigators- (1) Exchange shall establish program . . . awards grants to entities . . . trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities * * * entity that serves as a navigator under a grant shall-- (A) conduct public education activities to raise awareness of the availability of qualified health plans; (B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions; (C) facilitate enrollment in qualified health plans; (D) provide referrals to any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan; and (E) provide information in a manner that is culturally and linguistically appropriate

a navigator shall not--(i) be a health insurance issuer; or (ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

The Secretary, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange

SEC. 1312. CONSUMER CHOICE.

(a) Choice- (1) **QUALIFIED INDIVIDUALS**- A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) **QUALIFIED EMPLOYERS**- (A) **EMPLOYER MAY SPECIFY LEVEL**- A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange. (B) **EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL**- Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

* * *

1312 (f) Qualified Individuals and Employers; Access Limited to Citizens and Lawful Residents-

(1)(A) The term 'qualified individual' means, with respect to an Exchange, an individual who-- (i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and (ii) resides in the State that established the Exchange. (B) INCARCERATED INDIVIDUALS EXCLUDED- An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER- In this title: (A) IN GENERAL- The term 'qualified employer' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans. * * *

(3) ACCESS LIMITED TO LAWFUL RESIDENTS- If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) Accounting for Expenditures- (1) IN GENERAL- An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings. (2) INVESTIGATIONS- The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) AUDITS- An Exchange shall be subject to annual audits by the Secretary.

* * *

(b) GAO Oversight- Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges.



SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS

- (a) – (1) HHS shall issue regulations setting standards under this title re: (A) establishment and operation of Exchanges; (B) offering of qualified health plans through such Exchanges; (C) the establishment of the reinsurance and risk adjustment programs under part V; and (D) such other requirements as the Secretary determines appropriate.
- (b) State Action- Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect--
 - (1) the Federal standards established under subsection (a); or
 - (2) a State law or regulation that the Secretary determines implements the standards within the State.



1321 (c) Failure To Establish Exchange or Implement Requirements-

(1) IN GENERAL- If--

(A) a State is not an electing State under subsection (b); or
(B) the Secretary determines, on or before January 1, 2013, that an electing State--

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement--

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

1321 (e) Presumption for Certain State-Operated Exchanges-

(1) IN GENERAL- In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) PROCESS- The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1334. MULTI-STATE PLANS

Office of Personnel Management - shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State.

OPM shall ensure that at least one contract is entered into with a non-profit entity.

OPM shall implement this subsection in a manner similar to . . . the Federal employees health benefit program . . . , including (through negotiating with each multi-state plan)--

- (A) a medical loss ratio;
- (B) a profit margin;
- (C) the premiums to be charged; and
- (D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.



SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL MARKET

- (a) In General- Each State shall, not later than January 1, 2014
 - (1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and
 - (2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

Temporary 3-year program plan year beginning Jan. 1, 2014

Health insurance issuers and TPAs on behalf of group plans pay

High risk individuals – list of 50 – 100 medical conditions

SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS

(a) HHS - program of risk corridors for calendar years 2014, 2015, and 2016 qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on ratio of allowable costs to the plan's aggregate premiums.

(b) Payment Methodology- (1) PAYMENTS OUT- (a) that if-- (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN- (a) that if--

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

SEC. 1343. RISK ADJUSTMENT

- (a) In General- (1) LOW ACTUARIAL RISK PLANS- each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).
- (2) HIGH ACTUARIAL RISK PLANS- Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).
- (b) Criteria and Methods- The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.



Agenda

1. Overview of Idaho Market
2. Review of Prior DOI Activities/Planning for Exchange
3. Overview of PPACA Insurance and Market Reforms
-  4. Exchange Overview
5. Exchange Options and Critical Dates
6. Charge to Working Group & Next Steps



Exchange Overview



Summary

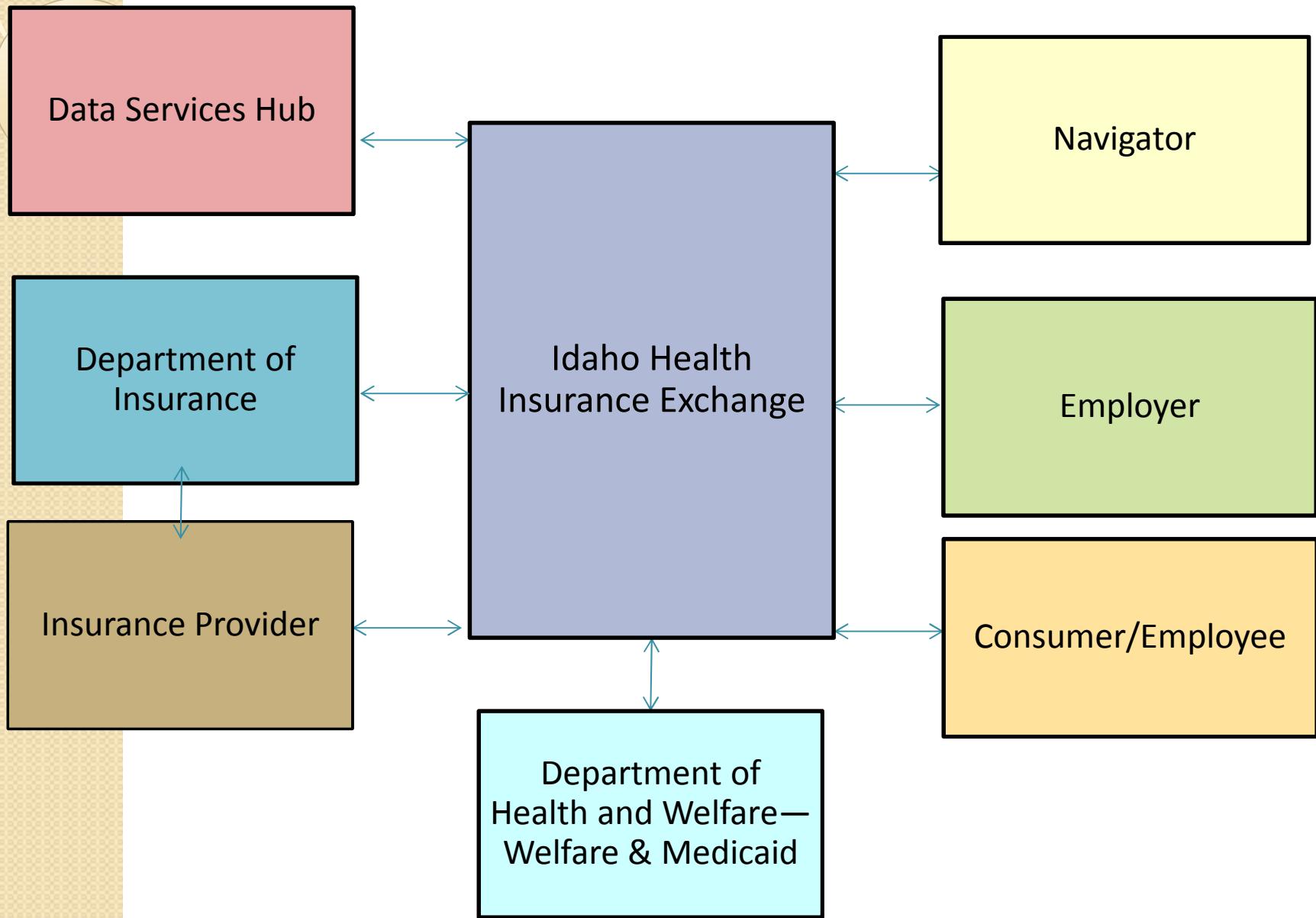
1. PPACA provides for the establishment in each State of an Affordable Insurance Exchange.
2. To help qualified individuals and qualified small employers to purchase health insurance coverage offered by qualified health plans.
3. A mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.
4. Exchanges will assist eligible individuals to receive premium tax credits or coverage through other Federal or State health care programs

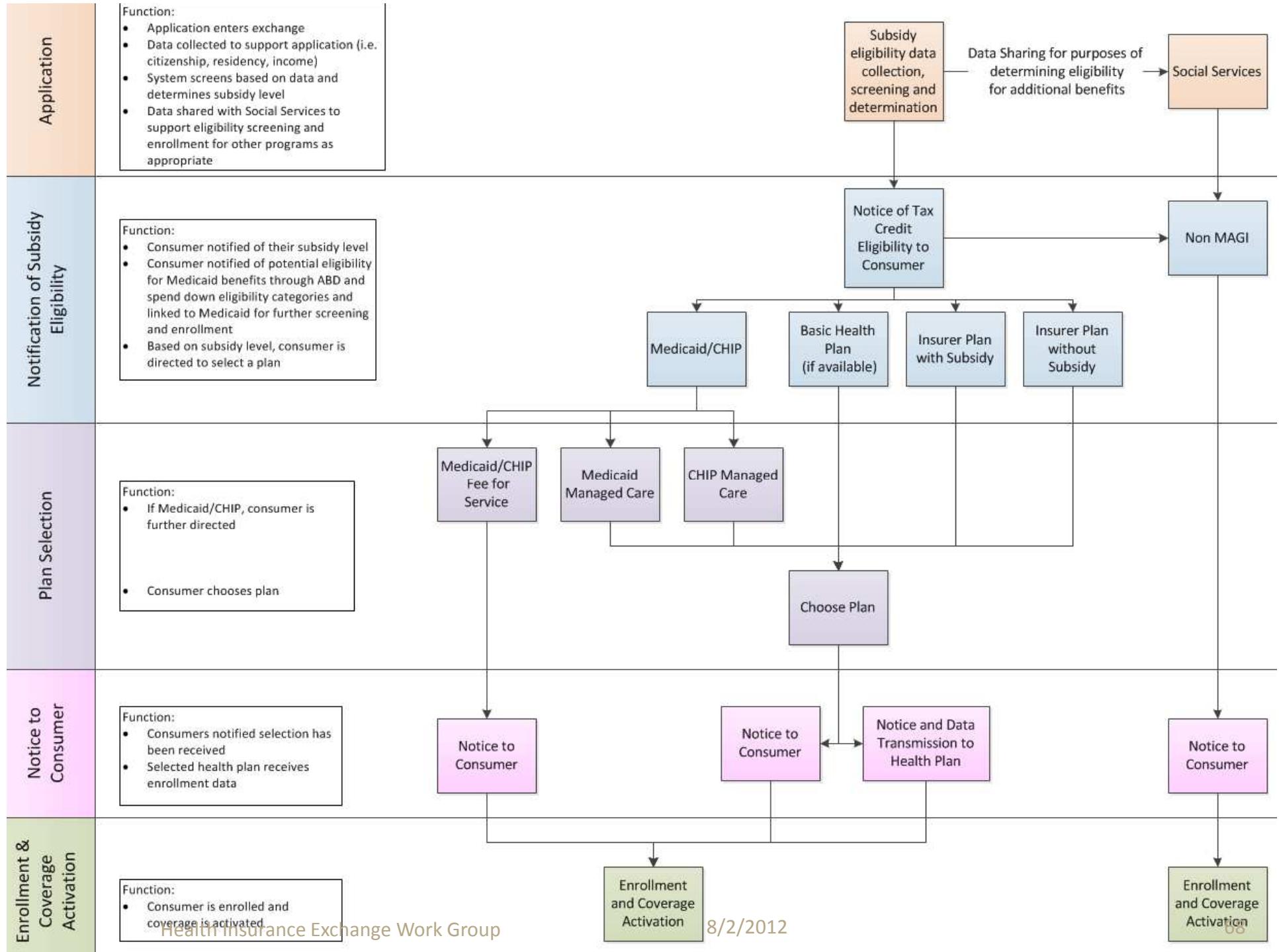


Summary

5. **Exchanges will increase access to coverage** by providing a single point of access for consumers to receive eligibility determinations for enrollment in the Exchange and for insurance affordability programs.
6. **Exchanges will increase competition among issuers** by permitting consumers and employers to easily compare qualified health plans that meet minimum quality and other standards.
7. **Each State may elect to establish an Exchange or rely on the Secretary of Health and Human Services** to establish an Exchange for that State.
8. **Coverage through the Exchange will begin in every State on January 1, 2014.**

Connections







What Must an Exchange Do?

- As set forth in the final rule, Exchanges must:
 - Provide consumer support for coverage decisions
 - Facilitate eligibility determinations for individuals
 - Provide for enrollment in qualified health plans in the Exchange
 - Certify health plans as qualified health plans (QHPs)
 - Operate a Small Business Health Options Program (SHOP)



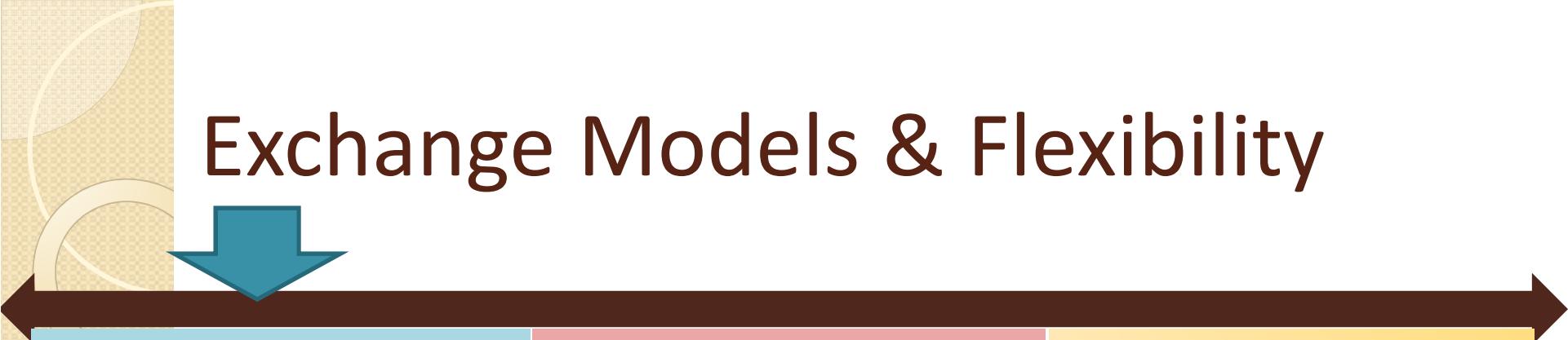
Exchange Components (Certification Requirements)

- Exchange Activities
 - Legal Authority and Governance
 - Consumer and Stakeholder Engagement and Support
 - Eligibility and Enrollment
 - Plan Management
- Financial Management
 - Associated Activities
 - Risk Adjustment
 - Reinsurance
 - Quality
- Administrative Activities
 - Organization and Human Resources
 - Technology (Hardware, Software, and IT Infrastructure)
 - Finance and Accounting
 - Privacy and Security
 - Oversight, Monitoring, Reporting



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Exchange Models & Flexibility

State-based Exchange

State operates all Exchange activities; however, State may use Federal government services for the following activities:

- Premium tax credit and cost sharing reduction determination
- Exemptions
- Risk adjustment program
- Reinsurance program

Partnership Exchange

State operates activities for:

- Plan Management
- Consumer assistance
- Both

State may elect to perform or can use Federal government services for the following activities:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

Federally-facilitated Exchange

HHS operates; however, State may elect to perform or can use Federal government services for:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols



**Idaho
performs
all
functions
of the
Idaho
Exchange**

Exchange Components (Certification Requirements)

- Exchange Activities
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Blueprint Requirements (November 16, 2012)

- SBE
 1. Legal—Law or Executive Order; Board composition
 2. Consumer Assistance
 - Stakeholder consultation plan and progress
 - Outreach plans, targets for populations
 - Description of call center strategy, volumes
 - Website URL, strategy
 - Description on plan to operate a Navigator program including conflict of interest, training, timeline and funding
 3. Eligibility and Enrollment
 - Single, streamlined application
 - Coordination strategy with agencies
 - Description of data matching
 - Description of how verifications will be conducted
 - Description of end-to-end processes



Blueprint Requirements (November 16, 2012)

- SBE (continued)

- 4. Plan Management

- Description of QHP certification, decertification and recertification standards
 - Description of roles and responsibilities
 - Description of integration points
 - Description of health plans, collection methods and applicable systems
 - Description of issuer technical assistance and support

- 5. Risk Adjustment and Reinsurance

- Describe entity operating risk adjustment
 - Describe entity and process for collecting contributions
 - Describe timelines for modifications

- 6. SHOP

- Describe small business market
 - Describe process, systems requirements and capacity



Blueprint Requirements (November 16, 2012)

- SBE (continued)

- 7. Organization and Human Resources

- Describe organizational chart, strategy for hiring, competencies, roles & responsibilities needed

- 8. Finance and Accounting

- Describe methods to generate revenue and how to handle deficits
 - Describe model budget with operating costs, revenues and expenditures

- 9. Technology

- Describe areas of variation and system functionality
 - Describe front-end system engineering, quality assurance, validation of requirements, business processes



Blueprint Requirements (November 16, 2012)

- SBE (continued)

10. Privacy and Security

- Describe a plan to establish privacy and security standards, policies and procedures

11. Oversight and Monitoring

- Description of plan, including specific protocols for quality monitoring and performance metrics
- Description of financial standards and compliance

12. Contracting, Outsourcing and Agreements

- List of all contractors the state has contracted and note services contractors will support



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Exchange Components (Certification Requirements)

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Guiding Principles for an FFE

- **Commitment to Consumers.** HHS' goal is to ensure that consumers in all States have access to high-quality, affordable health coverage options through an Exchange.
- **Market Parity.** HHS will work to harmonize State market requirements inside and outside of an FFE, to:
 - Promote the competitiveness of each FFE
 - Minimize administrative burden for issuers
 - Ensure consumer protections
- **Leveraging traditional State Roles.** HHS will seek to capitalize on existing State policies, capabilities, expertise, and infrastructure. This expands the work of the DOI's traditional roles.
- **Engagement with States and stakeholders.** HHS will seek input from a variety of stakeholders to support and inform decision-making, and will communicate our progress regularly.



Exchange Models & Flexibility



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- Reinsurance program
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*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols

Partnership Exchange Components

HHS performs all functions of the Idaho Exchange except...

- Exchange Activities
 - Legal Authority and Governance
 - **Consumer and Stakeholder Engagement and Support**
 - Eligibility and Enrollment
 - **Plan Management**
- Financial Management
 - Associated Activities
 - Risk Adjustment
 - Reinsurance
 - Quality
- Administrative Activities
 - Organization and Human Resources
 - Technology (Hardware, Software, and IT Infrastructure)
 - Finance and Accounting
 - Privacy and Security
 - Oversight, Monitoring, Reporting



Partnership Options

- States can choose to administer selected functions in partnership with an FFE. States can choose one or both options:
 - **State Partnership in plan management**
 - State Partner will be responsible for plan management activities, such as certification, recertification, and decertification of QHPs; data collection and transmission; and issuer oversight and management, subject to federal law and oversight.
 - **State Partnership in consumer assistance**
 - State Partner will provide in-person assistance to individuals, including filling out and submitting an application, comparing and selecting a QHP, and enrolling in coverage. HHS will operate the call center and website.



Partnership Administration

- Partnership options will increase State control over key business areas.
 - Partnership options will allow States to serve as first-line resources to issuers and consumers.
 - State Partners will be approved to carry out plan management or consumer assistance functions for both the individual and small group markets.
- HHS will approve inherently governmental decisions on an ongoing basis.



Blueprint Requirements (November 16, 2012)

Partnership

2. Consumer Assistance

- Description on plan to operate a Navigator program including conflict of interest, training, timeline and funding

4. Plan Management

- Description of QHP certification, decertification and recertification standards
- Description of roles and responsibilities
- Description of integration points
- Description of health plans, collection methods and applicable systems
- Description of issuer technical assistance and support

5. Risk Adjustment and Reinsurance

- Describe entity and process for collecting contributions
- Describe contractors and roles

13. State Partnership Agreements



Exchange Models & Flexibility



State-based Exchange

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- Reinsurance program

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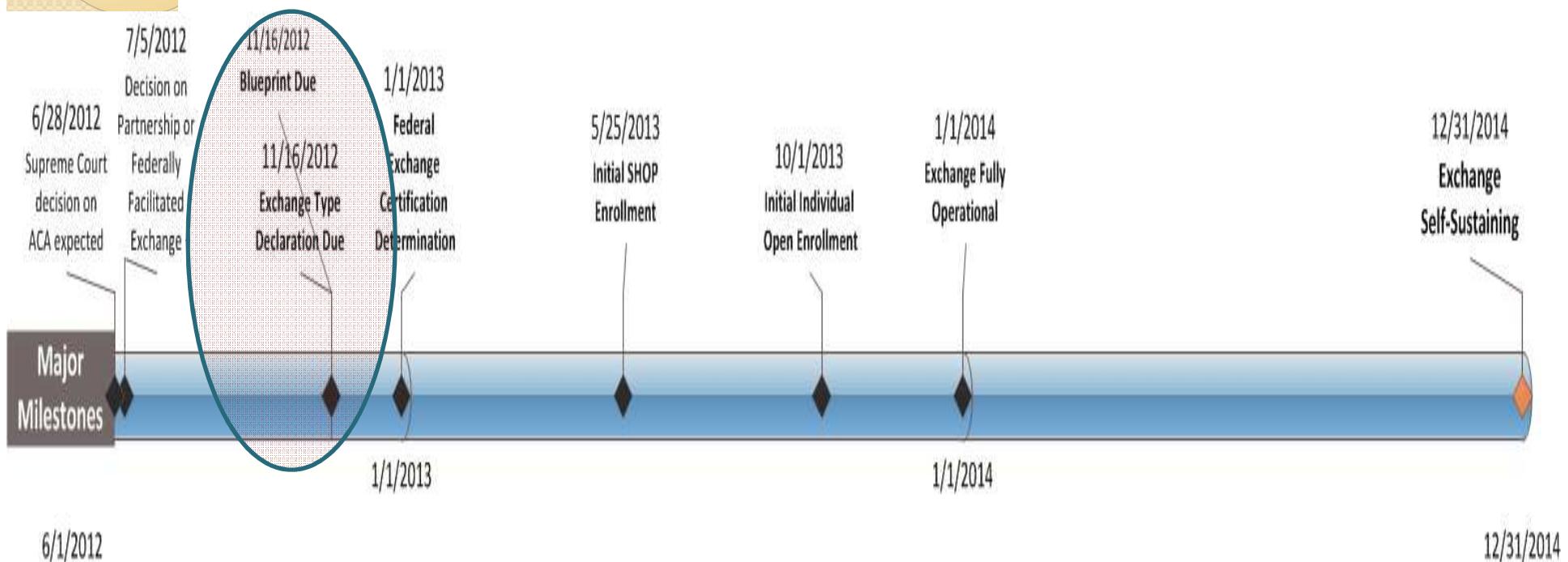
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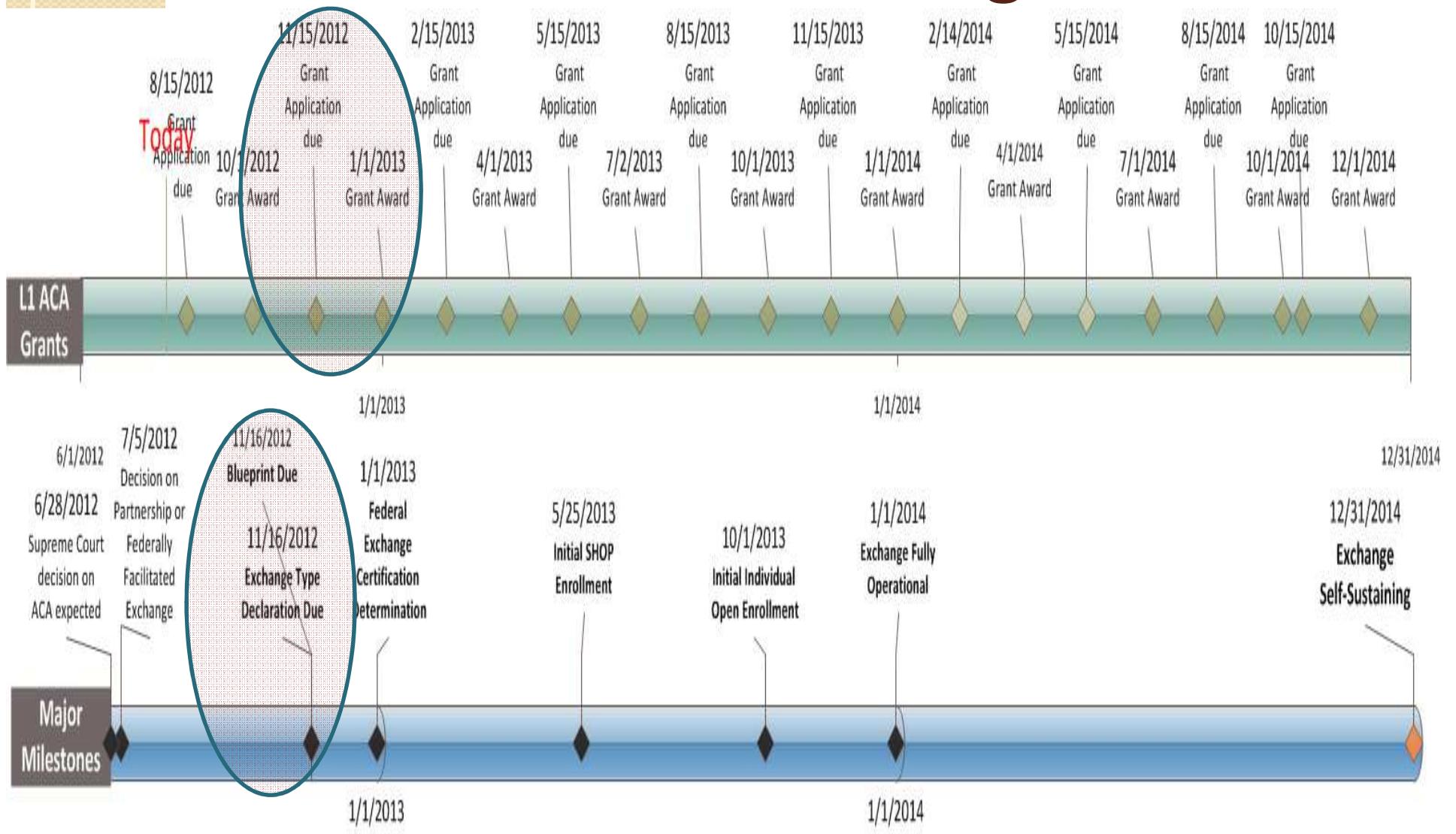


• Critical Dates

High-Level Exchange Milestones

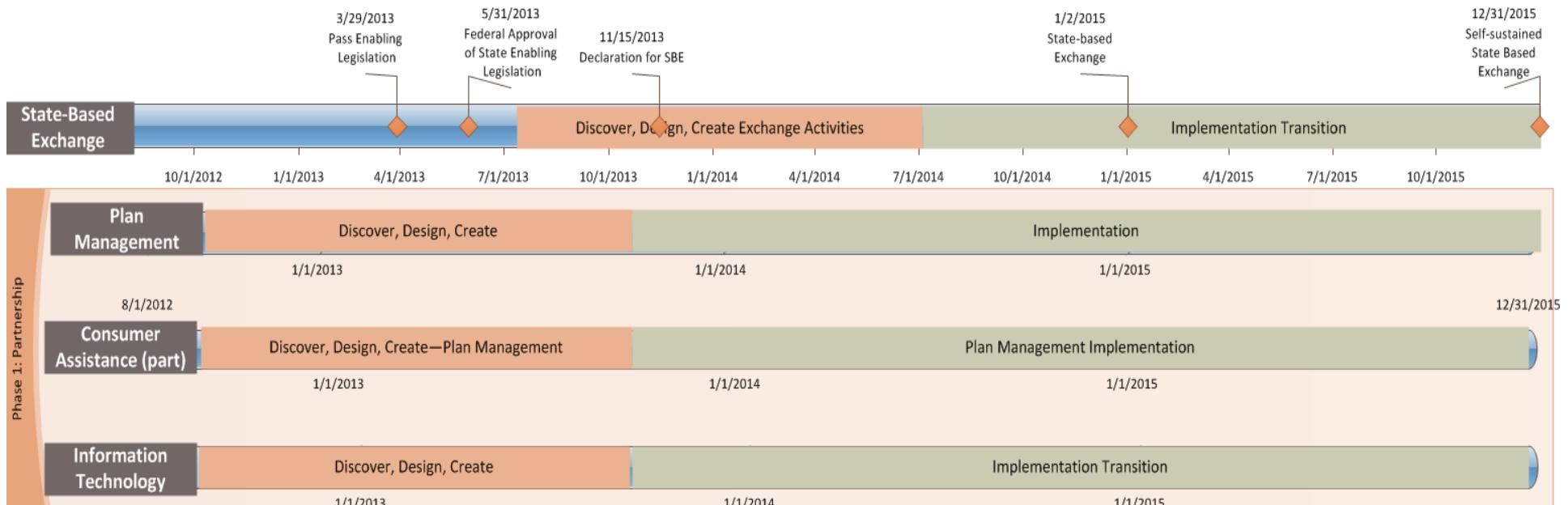


Milestones and Funding

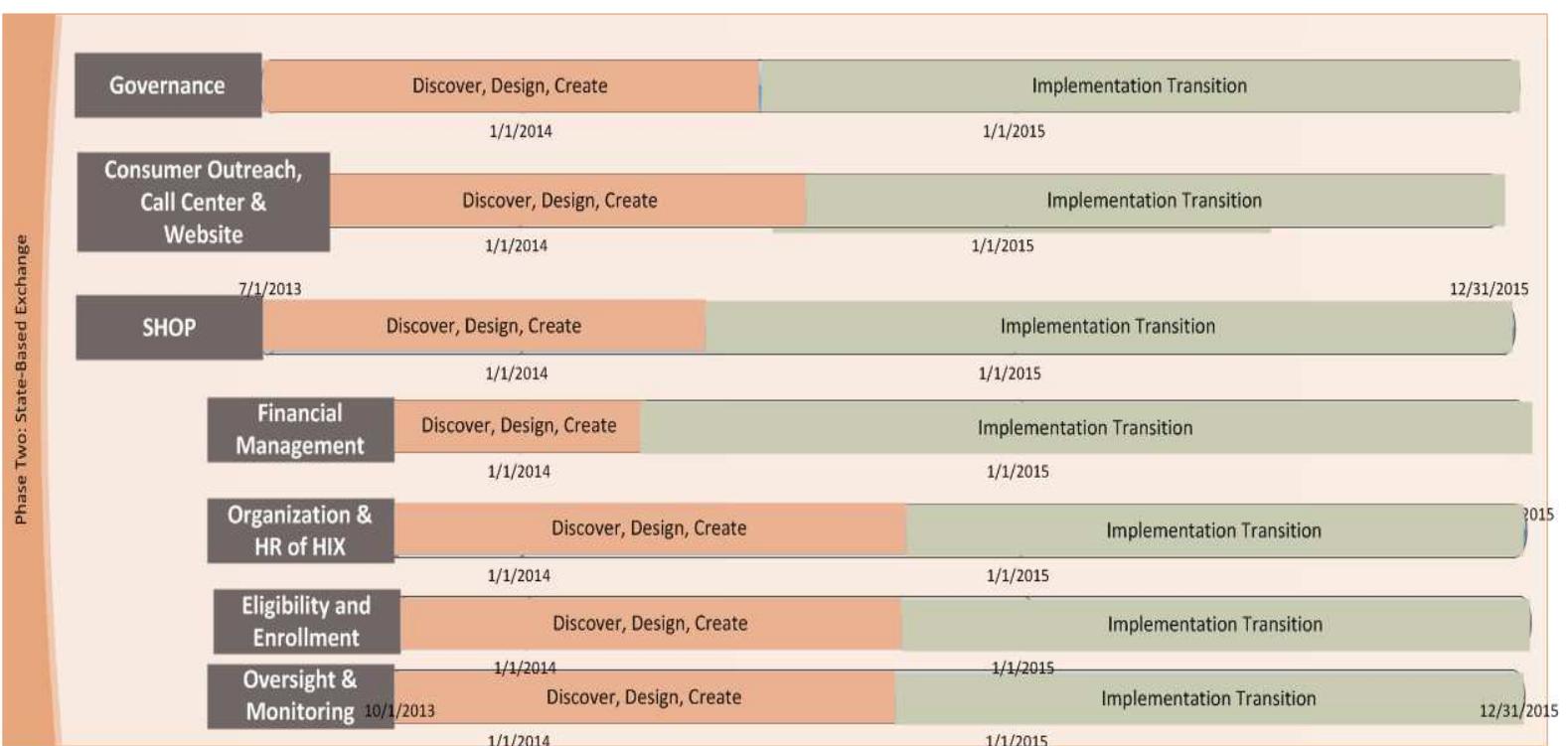


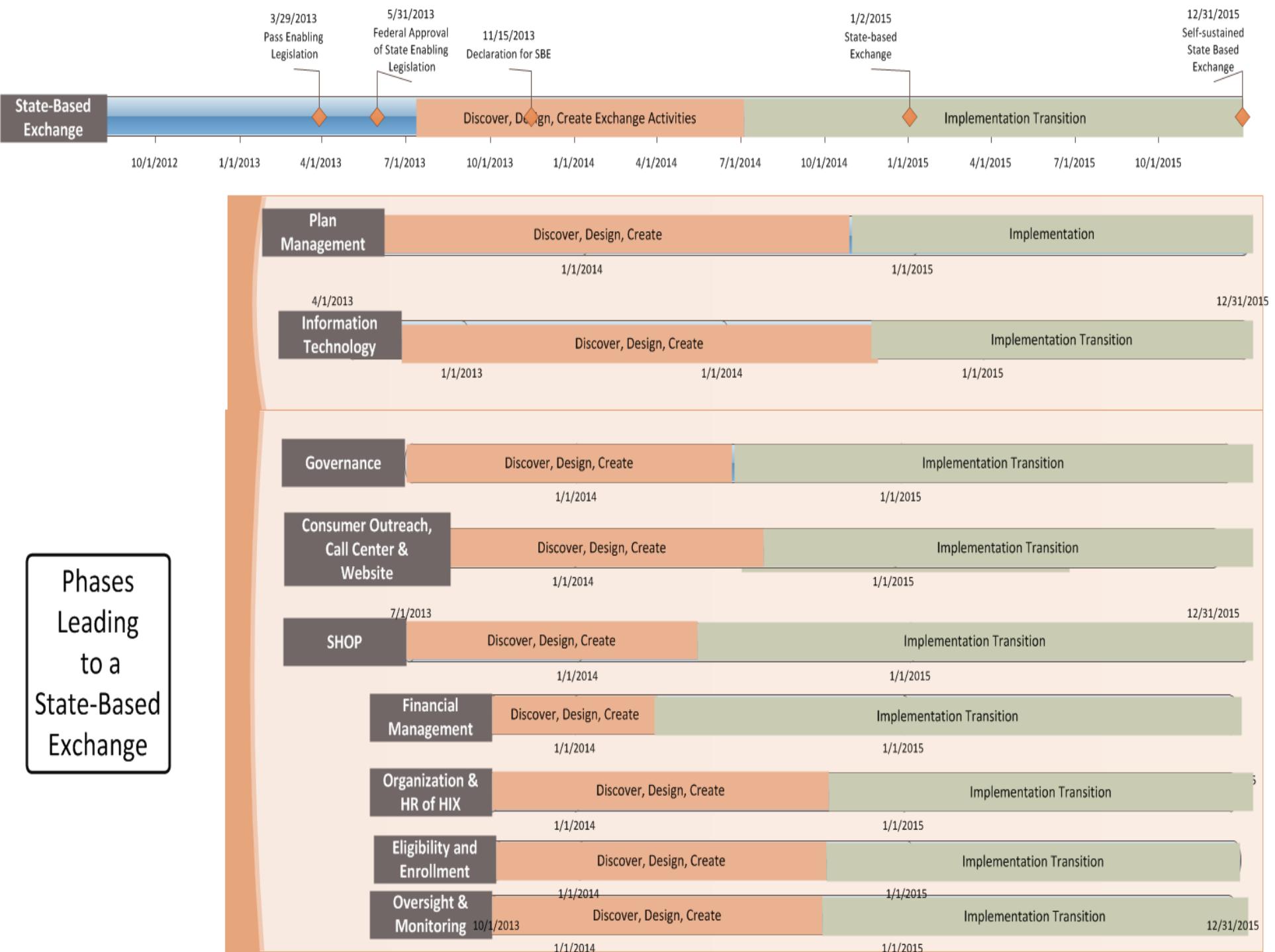
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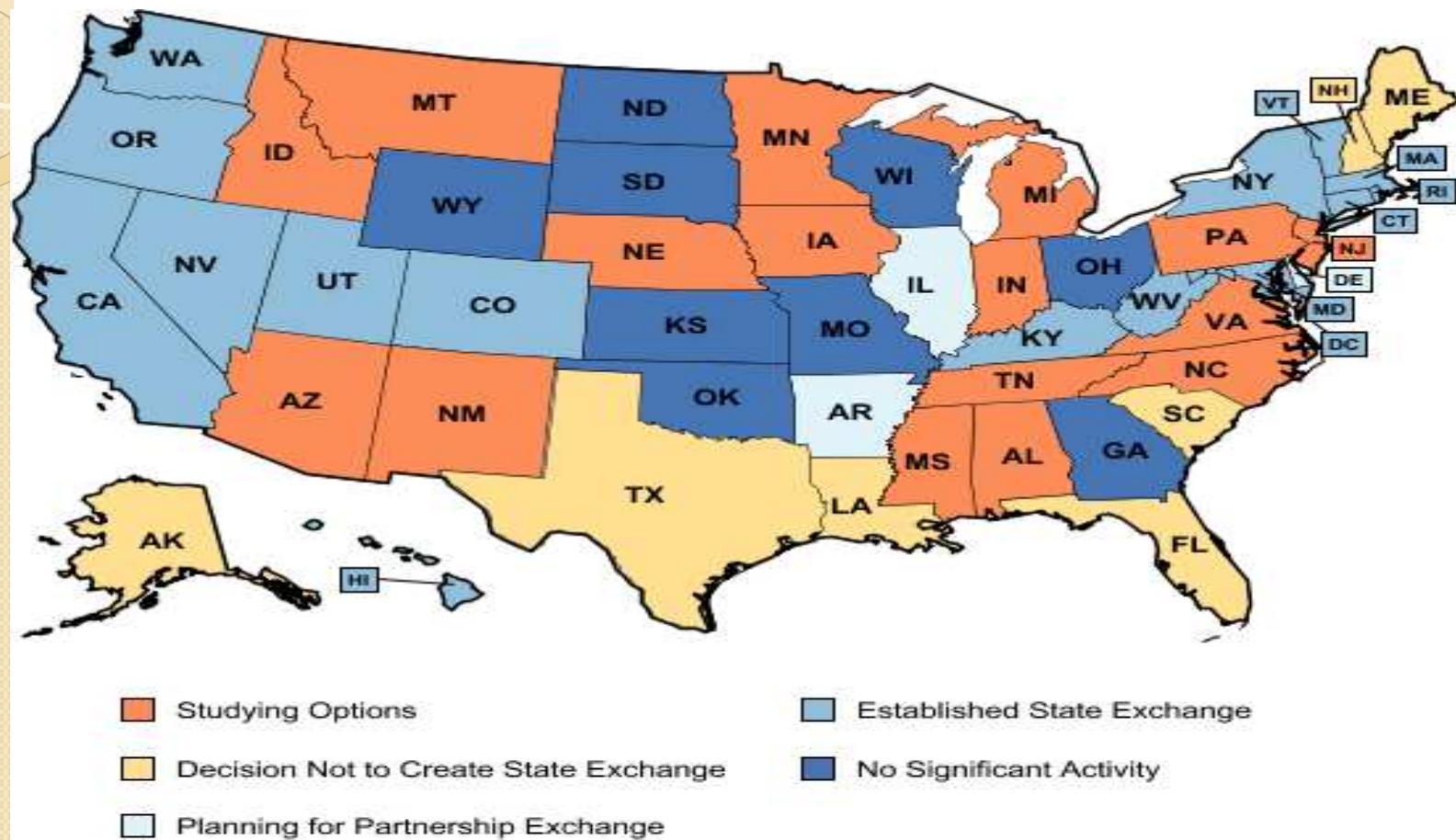


Phases Leading to a State-Based Exchange





Status of State Action



State Action Toward Creating Health Insurance Exchanges, as of August 1, 2012: Status of State Action



statehealthfacts.org
Your source for state health data

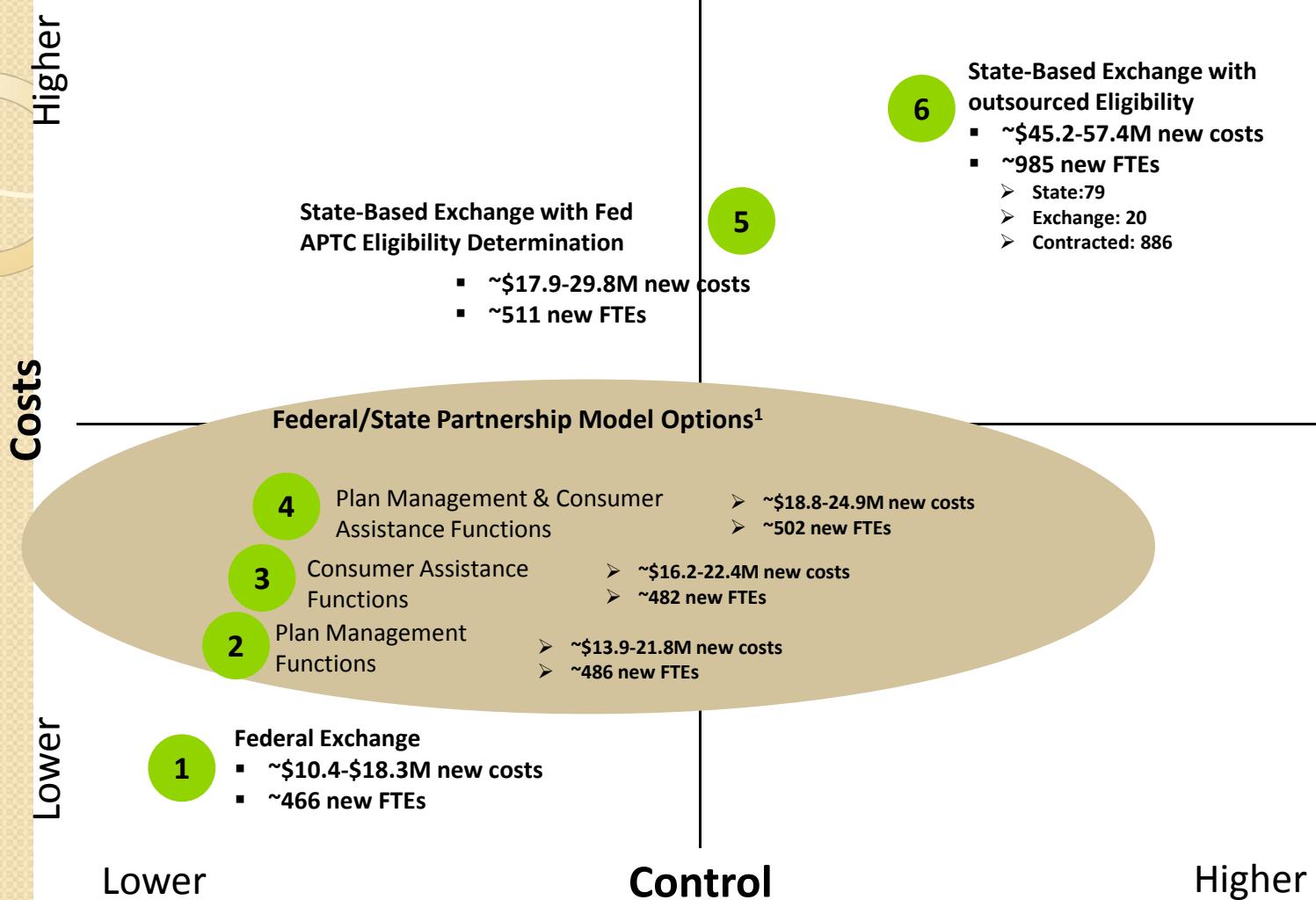
<http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=1/> retrieved August 1, 2012



Costs

- State Based Exchanges (Start up Grants)
 - Oregon = \$60M
 - Washington = ~ \$150M
 - Maryland = \$34.4M
- Federally Facilitated Partnership
 - Delaware--TBD
 - Arkansas-- TBD
- Federally Facilitated
 - Arizona est. \$9.6M

Indiana: Preliminary & Draft Operational Costs for Exchanges



¹ For the Federal Exchange and 3 Federal/State Partnership model options, technology estimates include staff and “other maintenance” costs but do not include a PMPM charge that the Federal government is considering for each member utilizing the Exchange, which may add an incremental \$9.0M or more in annual costs. They also do not include a potential additional Design, Development and Implementation (DDI) cost of \$10.5M for not performing Eligibility.

Delaware

Table 6-3: Total Cost and PMPM for Each Option at Different Enrollment Levels

	5,000 Enrollees	35,000 Enrollees
State Exchange - Partially Outsourced - Total Costs	\$5,204,971	\$6,554,473
State Exchange - Partially Outsourced - Revised PMPM	\$86.75	\$15.61
State Exchange - Fully Outsourced - Total Costs	\$2,149,081	\$4,534,988
State Exchange - Fully Outsourced – Revised PMPM	\$35.82	\$10.80
Federal Partnership Consumer Assistance - Total Costs	\$1,963,036	\$4,280,834
Federal Partnership Consumer Assistance – Revised PMPM	\$32.72	\$10.19
Federal Partnership Plan Management - Total Costs	\$2,053,306	\$4,409,796
Federal Partnership Plan Management - Revised PMPM	\$34.22	\$10.50
Federal Partnership Consumer Assistance and Plan Management - Total Costs	\$2,227,214	\$4,613,113
Federal Partnership Consumer Assistance and Plan Management – Revised PMPM	\$37.12	\$10.98
Full Federal Model – State Costs	\$839,037	\$2,999,037
Full Federal Model – Revised PMPM	\$13.98	\$7.14



Assessment of Options: Arizona

System Vendor Role	Option				
	1	2	3	4	5
	Use the Federal Exchange	Joining and Multi-State Solution **	Leveraging Existing Arizona		Build from Scratch (Rip and Replace) ***
State Total State Resource Cost Estimates	\$ 746,504	\$ 1,007,689	\$ 1,254,904	\$ 1,431,052	\$ 4,293,156
Total Contractual (Vendor) Cost Estimates	\$ 8,871,000	\$ 21,871,000	\$ 19,973,000	\$ 20,150,000	\$ 120,000,000
Total Estimated Costs by Option	\$ 9,617,504	\$ 22,878,689	\$ 21,227,904	\$ 21,581,052	\$ 124,293,156
Financing Options	Uncertain	Establishment and 90/10	Establishment, 90/10, GUX, Subscription Model	Establishment, 90/10, GUX, Subscription Model	Establishment, 90/10, GUX, Subscription Model
Meet ACA Timeline?	Likely	Not likeley	Moderately Likely	Not Likely	Least Likely
Risks (e.g. Complexity, Control, Known vs. Unknown, Time, Costs, Performance, Strategic Alignment, Consumer Acceptance, Political)	Moderate	High	Lowest	Moderate	High

"ACA Health Insurance Exchange Gap Analysis: Arizona" Social Interest Solution, June 1, 2011





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DOI Assist Questions

1. Does the DOI have any federal requirements to meet if the state chooses to do nothing?
4. What funding sources are available for the different exchange options and when and how are the funding sources available?
5. When are the key deadlines and benchmarks for each available option? Is it still possible for the state to establish a SBE or Partnership within the timeframe required by PPACA, and if so that is the latest date formal work must begin on each?



DOI Assist Questions

6. Some critics of establishing a state exchange point to detailed requirements mandated by the federal government. In what ways would each option differ with regard to these requirements and how much flexibility is afforded the state in setting up a SBE or Partnership?
9. Does the decision on Idaho choosing to expand or not to expand Medicaid impact the exchange decision, and if so how?
10. What options are available to the state regarding Choosing a benchmark plan for the Essential Health Benefits and when must that be done? Does the potential decision by the state in choosing the benchmark plan impact the exchange decision?



DOI Assist Questions

11. How do the PPACA requirements regarding reinsurance, risk corridors and risk adjustment impact the exchange decision, if at all?
14. Does the federal government intend to maintain high-risk pools and how will they be financed? What actions will they take in a state that has opted not to operate a high-risk pool or an exchange?



Possible Contracted Research

3. How much would each option (SBE, FFE, FFE-P) cost to establish initially and to maintain going forward?
7. Recognizing that the federal government has indicated that a state which starts with a FFE could transition in the future to a Partnership or SBE, what are any benefits and disadvantages to this approach? What differences might there be with regard to cost?
8. How will each type of exchange affect the current market, consumers and industry?



Possible Contracted Research

12. States need to know the details of the operational systems for the federal exchange. The procedural, technical and architectural requirements for linking to the federal exchange have not been released. How can a state know if a SBE is better for our citizens until we know what the contents of a federal exchange will be?
13. Will states considering a SBE be able to determine whether there will be a charge—and if so, how much—to use the federal data hub, advance premium tax credit/cost-sharing reduction service, risk adjustment and transitional reinsurance program?



Next Steps



• ° Thank you



- Extra slides

